EXHIBIT "D"

DEPOSITION EXCERPTS

OF

DAVID BAZEMORE

Page 57

of eye diseases or blindness in the family. They're asked if they have any general health problems, and if so, who's their medical doctor that treats those and what medications they're on and if they're allergic to any medicine.

Let's see. I'm trying to go down the list. I think that's about it.

Q. What about with an existing patient? What kind of case history?

A. My part of asking them questions would be the same.

Q. What about the forms for an existing patient?

A. The medical record part with the exam results looks the same either way. They're just asked to fill out additional sheets for their first visit.

Q. Okay. What is the purpose of a case history?

A. To identify the problems and needs of the patient and to try to remedy those.

Q. All right. And what kind of problems and

Page 58

needs are you looking for?

A. Any kind they might have.

Q. Okay. Let me just kind of back up a minute. Do you know what the leading causes of blindness are, say, in this country?

A. In this country?

Q. Yes, sir.

A. It varies from region to region, depending on the demographics of the different areas. Okay? Right now, probably the leading cause in the country as a whole is macular degeneration.

Q. Okay. What else?

A. Well, that would be the leading one.

Q. All right. Well, causes, I guess, is what I intended to ask. I may not have -- but what else is a leading cause of blindness?

A. Glaucoma would be one of the leaders and probably -- I don't know. Past there, I would be hesitant to say because they're all the time updating that every six months to a year.

Page 59

Q. Do you subscribe to any publications that keep you apprised of new developments in the optometric field?

A. Yes.

Q. What publications do you subscribe to?

A. Review of Optometry. American Optometric Association has a thing they put out monthly, a journal. Optometric Management. Vision Monday is another.

Oh, goodness. Let's see. Which ones have I said so far?

Q. Review of Optometry, American Optometric Association publication, Optometric Management, and Vision Monday.

A. Okay. There's another one called 20/20.

Q. Okay. Anything else that you take?

A. If so, I can't remember it right this minute.

Q. So of these five publications you listed, do you subscribe to all of them?

A. Yes.

Q. And is Review of Optometry -- how often does that come out?

Page 60

A. Monthly.

Q. And you said American Optometric Association is monthly?

A. Monthly.

Q. Optometric Management. How often?

A. Monthly.

Q. All right. And Vision Monday?

A. Monthly.

Q. And 20/20?

A. Same, monthly.

Q. All right.

A. The Alabama Optometric Association also puts out a newsletter that's monthly.

Q. Now, how often do you read these publications? I mean, do you read it cover to cover every month?

A. Probably most of the time.

Q. Okay. And that would go for all of them, all six of them?

A. (Witness nods head up and down.)

Q. Is that a yes?

A. Yes.

Q. All right. So based on what you were

Page 53

optometric visit. Is that a fair definition?
A. There is no minimum things that should be done at every office visit that comes in. It would vary depending upon the patient's needs.
Q. Well, I'll tell you what. I don't know why, but it seems like we're having trouble with this, so let me just -- I'm going to read this into the record, and you tell me if I read anything wrong. Okay?
630-X-12-.06, failure to meet standard of care. The board shall consider it unprofessional conduct for a licensee to provide for a patient care that is less than the generally accepted standard of care. This standard of care shall include but not be limited to providing certain minimum testing for the patient when performing a comprehensive eye exam. A comprehensive eye exam shall include any examination wherein a prescription for glasses or contact lenses or necessity

Page 54

thereof is determined. Minimum testing for a comprehensive eye exam shall include a case history, determination of refractive error, binocular vision evaluation, ophthalmoscopy, evaluation of health of external eye and adjacent structures, tonometry or other appropriate glaucoma testing, and such other tests as are necessary under the circumstances. Failure to perform said minimum testing during a comprehensive eye exam shall constitute failure to meet the standard of care.
Did I read this paragraph correctly?
A. I thought so, yes.
Q. Okay. I didn't misstate anything?
A. No.
Q. All right. And do you agree that this is the minimum that an optometrist should do?
A. For a comprehensive eye exam?
Q. Yes.
A. I would agree with that.
Q. Okay. So you agree that minimum testing for a comprehensive eye exam must include a

Page 55

case history?
A. Yes.
Q. Okay. And it must include a determination of refractive error?
A. Yes.
Q. All right. Let's back up. How do you go about getting a case history?
A. It depends on whether it's a new patient or a former patient. New patients are asked to fill out some questions, answer some questions that are on the registration form, and all of the patients, whether they're old or new patients, are given an oral case history.
Q. Okay. And do you ask questions of the patients?
A. Yes, I do.
Q. Okay. What questions do you ask?
A. Is this a new patient or an old patient?
Q. Well, let's take a new patient first.
A. Okay. The questions that they're asked to fill in on the sheet are whether -- well, there's several questions on there. I

Page 56

don't have one in front of me. But basically, I'm going to go back through those questions and ask them if there was any -- if there were yeses and nos on that, then I'm going to explore the yeses and see what's going on there. Then I will also ask them some other questions under an oral history and write them down on the actual front exam area of the medical record.
Q. All right. And what questions do you ask them on the oral history?
A. They're asked if they have been in before, and if so, how long it has been. They are asked why they're there today. Was it time for a routine exam, or are they having problems? If so, what kind of problem are they having? They're asked if they're on any medicine for anything or have any general health problems or if they're allergic to any medicine. They're asked if they've ever had any operations or injuries or infections or surgery on their eyes. They're asked if there's any family history

Page 209

Q. Or the origin of the symptoms, correct?
A. The origin of the symptoms, I'm not sure -- you would have to be more specific than that.
Q. Yeah, you're right. That's not a real good question.
It doesn't matter -- your duty doesn't change if somebody comes in with glaucoma pursuant to an injury or glaucoma pursuant to some other cause, does it? Your duty to provide good care is the same, correct?
A. My duty is to try to figure out if they do have glaucoma, and if they do, then to try to get something done about it.
Q. Whether or not that glaucoma originates from an injury or some other cause, right?
A. That's true.
Q. Okay. How could the gonioscopy have aided in the diagnosis of narrow angle glaucoma in Kyle Bengtson?
MR. WHITE: Object to the form.
A. Somebody who actually saw him when he had angle closure glaucoma would be better able

Page 210

to answer that question. I don't know exactly what was going on with him at that time. It wasn't doing that when I saw him.
Q. Okay. Whether or not he had a closed angle at the time he came to see you, based on his complaint that he was seeing halos around lights, why was the gonioscopy not performed?
A. There was no indication to perform it.
Q. Would Goldmann tonometry have aided you in your diagnosis?
A. No more so than what we had already.
Q. And are Goldmann tonometry and applanation tonometry the same thing?
A. There are other kinds of applanation tonometry.
Q. I'm just going to show you this. We may make it an exhibit, but -- I'll show it to your attorney. That's just something I found on the internet, and I'll be glad to share a copy with your lawyer if you want to. This is just something that --
MR. WHITE: You want him to read

Page 211

it?
MR. ADAMS: I'm just going to ask him about it.
MR. WHITE: He needs to read it first.
Q. Well, you can read it. Sure. No problem.
MR. WHITE: Well, and we're not going to answer questions about it unless you're going to make it an exhibit to the deposition.
MR. ADAMS: That's fine. I'll make it an exhibit. That's fine.
(Plaintiff's Exhibit 6 was marked for identification.)
Q. I'm just going to ask you about the middle paragraph there on the symptoms.
MR. WHITE: I don't think he's finished reading it. I know I'm not. We just finished the first paragraph.
MR. ADAMS: All right.

Page 212

Q. Okay. If you don't mind, just put this down on the table where we can both look at it.
A. Okay.
Q. All right. Where it says symptoms of narrow angle glaucoma, you agree with me that it says cloudy cornea there?
A. Correct.
Q. Blurring and decreased visual acuity. Do you see that?
A. Correct.
Q. Seeing halos around lights. Do you see that?
A. Well, I saw it, yes.
Q. All right. Are you aware that this kind of information -- I'll just represent to you that this kind of information regarding the signs and symptoms of angle closure glaucoma is readily available to a layman over the internet. Are you aware of that?
A. I would think probably so.
Q. Okay.
A. If they looked under -- you could do it

Page 225

A. No.
Q. Okay. Do you agree that because you can't predict what lies ahead, you have to prepare for the worst?
MR. WHITE: Object to the form.
A. No, I don't agree with that.
Q. Why not?
A. Well, do you sleep in the basement in case you have a tornado?
Q. I don't have a basement, but anyway. If you see a tornado coming, do you sleep in your basement?
A. If I saw one coming, I would.
Q. Because you're concerned for your safety, correct?
A. That, and more so my family's.
Q. And as an optometrist, it's your duty to be concerned for the safety of those people who come to you as patients, correct?
A. That's what they're coming in for.
Q. And it is your job to see --
As you said in the first few minutes of this deposition, you are an optometrist,

Page 226

correct?
A. That's correct.
Q. And you are trained to examine eyes for eye problems such as glaucoma, correct?
A. Correct.
Q. And therefore, you are required to know the symptoms of glaucoma, correct?
A. Correct.
Q. So that you can see such a problem as glaucoma coming before it causes too much damage, correct?
MR. WHITE: Objection to the form. You can answer.
A. Well, glaucoma is not very predictable in the sense that until there are symptoms, you can't diagnose them as having them or not or signs. And the only way you can tell if they have it is through verification of different defects which we've already covered and gone through some of that.
Q. And the verification requires the implementation of your best tools, correct?

Page 227

A. It would depend on what kind of problems you detected as to what should be done next.
Q. Okay. All right. I'm done.
* * * * * * * * * * * * *
FURTHER DEPONENT SAITH NOT
* * * * * * * * * * * * *
REPORTER'S CERTIFICATE
STATE OF ALABAMA:
MONTGOMERY COUNTY:
I, Patricia G. Starkie, Registered Diplomate Reporter, CRR, and Commissioner for the State of Alabama at Large, do hereby certify that I reported the deposition of:
DAVID BAZEMORE, O.D.
who was first duly sworn by me to speak the truth, the whole truth and nothing but the truth, in the matter of:
KYLE BENGTSON,
Plaintiff,
vs.
DAVID BAZEMORE, O.D.,
Et al.,

Page 228

Defendants.
In The U.S. District Court
For the Middle District of Alabama
Eastern Division
Case Number 3:06-cv-00569-MEF
on May 15, 2007.
The foregoing 227 computer printed pages contain a true and correct transcript of the examination of said witness by counsel for the parties set out herein. The reading and signing of same is hereby waived.
I further certify that I am neither of kin nor of counsel to the parties to said cause nor in any manner interested in the results thereof.
This 30th day of May 2006.

Patricia G. Starkie, Registered Diplomate Reporter, CRR, and Commissioner for the State of Alabama at Large

Page 97

secondary causes. Acute just means that the pressure is real high.
Q. Well, let me ask you this. What type of glaucoma are you talking about when you say that -- when you say that there is a type of glaucoma where the pressure is not constantly high, it can come and go? What type of glaucoma is that?
A. That would usually -- it kind of depends on -- like I said earlier, there's variation in the pressure anyway. But if you have something -- if you're on certain medications that might cause your pupil to be dilated versus not dilated or if you have some -- well, there's a lot of things. I just really couldn't answer that for a blanket statement.
Q. All right. You have stated, again, that there is a type of angle closure glaucoma where the pressure is not constantly elevated, correct?
A. That's my understanding.
Q. Okay. If a patient presents in your office

Page 98

with signs and symptoms of glaucoma but not at that particular time elevated pressure, what do you do for that patient?
A. Again, it would depend on what other signs and symptoms there were. Okay? And the decision of when to have them back and check for this or that would depend on the other signs and symptoms if the pressure is normal.
Q. All right. Well, what if that sign and symptom --
I'm sorry. Did I cut you off?
A. Well, I'm just -- you know, I don't know if the pressure -- Well, that's all I know to say.
Q. What if the other signs and symptoms are -- include headaches and seeing halos around lights and blurry vision, but the pressure is not high at that particular time? What would you do for that patient?
A. Was this a new patient that I've never seen before?
Q. Let's take both situations. New patient

Page 99

you've never seen before.
A. Okay.
Q. What would you do?
A. I would first of all see what other things might be wrong that would cause the symptoms that you're talking about. Those are not limited to having glaucoma. In fact, that would be down the list of causes for those symptoms. It would be more common for them to have some other problems that would cause that.
If I had seen them before, then what I did or didn't do would be based on whether there was continuity from the times before, whether something was changing.
Q. Okay. Can glaucoma be managed via self-care at home?
A. That would depend on the type of glaucoma.
Q. Angle closure glaucoma. Can that be managed at home?
A. No.
Q. Not via self-care; correct?
A. I don't know of any cases where that's

Page 100

happened.
Q. Okay. If you suspect a patient of angle closure glaucoma, do you -- what do you do? If you suspect a patient of angle closure glaucoma, and you're at the end of the appointment, what next?
MR. WHITE: Object to the form. Can you define what you mean by suspect? I mean, I think he's already said what he does when they determine they have glaucoma.
Q. All right. If you are of the opinion that they may have angle closure glaucoma, and you're at the end of the appointment, what do you do?
A. I'm going to walk in and pick up the phone and call Medical Arts and ask them if he can go over there and let them look at him.
Q. Okay. And that's because you understand that angle closure glaucoma is a medical emergency, correct?
A. Correct.

Page 93

can vary, correct?
A. If the angle is closed, then the pressure will be elevated.
Q. Does the angle -- with angle closure glaucoma, is the angle always closed?
A. There are different kinds of angle closure glaucoma.
Q. Okay. And what are the kinds of angle closure glaucoma?
A. You can have a primary kind, you can have a secondary kind, and the secondary kind would be due to various things.
Q. Okay. What is primary?
A. The angle just closes off because of the anatomical shape of the person's anterior chamber angle.
Q. All right. What is secondary?
A. It has several different reasons that that could happen.
Q. Okay. Can you give me some of them?
A. They could have pigmentary glaucoma where it's clogging the trabecular meshwork. They could have an angle recession where

Page 94

there's damage to the trabecular meshwork. There are others that we can look up if you want to.
Q. Well, I'm just asking you the ones you remember as you sit here right now.
A. Right.
Q. Is that all of them?
A. You can have -- anything that got inside your eye, if you had trauma to your eye, and it -- there are other iris and corneal degenerative conditions that release cells that clog up the trabecular meshwork.
Q. When is glaucoma an emergency?
A. If they came in and the pressure is very high, then I'm going to pick up the phone and call the ophthalmology office and they're going over there then.
Q. Okay. And what if they come in and they -- their history is that they're having some signs and symptoms of glaucoma, but their pressure is not high? What do you do for that kind of patient? It's not high at that visit.

Page 95

A. I couldn't say. It would depend on other things about the patient.
Q. Okay. But would you still want to run tests for glaucoma if their history --
A. Every patient that comes in gets tested for glaucoma.
Q. How is angle closure glaucoma managed?
A. That would vary from case to case. I couldn't say.
Q. All right. Well, just say primary angle closure glaucoma. How do you manage that?
A. It depends on the elevation of the pressure, and I don't manage that. That's up to the ophthalmologist.
Q. You would send that person to an ophthalmologist?
A. Yes.
Q. What about secondary angle closure glaucoma? How is that managed?
A. If the pressure is elevated, it goes to the ophthalmologist.
Q. And what if the pressure is not elevated at that particular time?

Page 96

A. And what other signs make you think that they have glaucoma at that point?
Q. Well, I'm -- that's a good question. What other signs would there be that would make you be concerned about glaucoma?
A. Well, there's a lot of them, you know. We've been through this. But if their optic nerve head shows damage, if their cornea shows damage from the pressure being too high and other things like that that you have to look for as well as just the pressure.
Q. All right. Well, you've testified earlier that with angle closure glaucoma, there is a type of angle closure glaucoma where the pressure is not constantly elevated, correct?
A. That's right.
Q. All right. Would that be what's called acute angle closure glaucoma?
A. It would depend on whose book you were reading. The terms primary and secondary include that secondary are due to other

Page 125

agree to disagree over what it says.
Q. All right. Do you agree that the use of a gonioscopy better allows you to view the angle of the eye?
A. Well, what do you --
MR. WHITE: Object to the form.
A. We've covered this one before, too. I told you there were three main things. One was with the slit lamp, one was gonioscopy, and one was the OHT instrument.
Q. Of the three, which allows you to view the angle of the eye the best?
A. I would say the OHT instrument.
Q. Okay. And then what is the second best?
A. The gonioscopy.
Q. You've testified earlier that glaucoma is a serious medical condition that can result in blindness, correct?
MR. WHITE: Object to the form.
Asked and answered.
Q. You haven't changed your mind on that, have you?

Page 126

A. No.
Q. Okay. And that is something that you need as an optometrist to rule out when you see a patient who has some symptoms of glaucoma, correct? You need to rule out glaucoma, correct?
A. I need to rule out glaucoma, yes.
Q. Okay. And in order to do that, you need to view the angle of the eye, correct?
A. Not necessarily.
Q. All right. I'd like you to look at the first full paragraph in the next column. Do you see where it says, evaluation of the anterior chamber angle is best accomplished by gonioscopy? Do you see that?
A. I do.
Q. Do you agree with that?
A. Just a minute ago, we talked about the three most commonly used ways of doing that. And like I said, when the book was written, they didn't have some of the instruments available then that -- so this book is not -- it's outdated.

Page 127

Q. All right. But, now, did you have -- What did you call it, the OHD?
A. OHT. I'm not even -- that is an instrument that has only come out here in the last year or two, so I don't even know if he has one up there or not.
Q. So you didn't have an OHT in 2004?
A. No.
Q. All right. But you've already testified you had a gonioscopy in 2004?
A. Right.
Q. Okay. Do you agree with that statement, not -- Let's forget about the OHT for a moment. Between the other available methods of viewing the angle, do you agree that the gonioscopy is the better method than the slit lamp?
A. Right. Then the von Herrick screening method. Both of them require the slit lamp.
Q. Okay. All right. Next paragraph. It says, even when the anterior chamber angle is assessed as being narrow or even

Page 128

dangerously narrow, further information is often needed.
Do you agree with that?
A. I just have to have a minute to read what's there besides that one sentence, because that's not all that's involved with it.
Q. Well, take your time.
A. Okay. Now go ahead and ask me again, please.
Q. All right. When the anterior chamber is assessed as being narrow or even dangerously narrow, further information is needed, right? Do you agree with that?
A. Further information before you do what?
Q. Well, let me just ask you. If you see a very narrow angle, may not be closed but it's narrow, what do you do?
A. I am probably going to have that go to Medical Arts to see if they want to do a prophylactic laser procedure on that.
Q. And why is that?
A. Because I'm not allowed to do that procedure? Is that what you're asking?

Page 97

secondary causes. Acute just means that the pressure is real high.
Q. Well, let me ask you this. What type of glaucoma are you talking about when you say that -- when you say that there is a type of glaucoma where the pressure is not constantly high, it can come and go? What type of glaucoma is that?
A. That would usually -- it kind of depends on -- like I said earlier, there's variation in the pressure anyway. But if you have something -- if you're on certain medications that might cause your pupil to be dilated versus not dilated or if you have some -- well, there's a lot of things. I just really couldn't answer that for a blanket statement.
Q. All right. You have stated, again, that there is a type of angle closure glaucoma where the pressure is not constantly elevated, correct?
A. That's my understanding.
Q. Okay. If a patient presents in your office

Page 98

with signs and symptoms of glaucoma but not at that particular time elevated pressure, what do you do for that patient?
A. Again, it would depend on what other signs and symptoms there were. Okay? And the decision of when to have them back and check for this or that would depend on the other signs and symptoms if the pressure is normal.
Q. All right. Well, what if that sign and symptom --
I'm sorry. Did I cut you off?
A. Well, I'm just -- you know, I don't know if the pressure -- Well, that's all I know to say.
Q. What if the other signs and symptoms are -- include headaches and seeing halos around lights and blurry vision, but the pressure is not high at that particular time? What would you do for that patient?
A. Was this a new patient that I've never seen before?
Q. Let's take both situations. New patient

Page 99

you've never seen before.
A. Okay.
Q. What would you do?
A. I would first of all see what other things might be wrong that would cause the symptoms that you're talking about. Those are not limited to having glaucoma. In fact, that would be down the list of causes for those symptoms. It would be more common for them to have some other problems that would cause that.
If I had seen them before, then what I did or didn't do would be based on whether there was continuity from the times before, whether something was changing.
Q. Okay. Can glaucoma be managed via self-care at home?
A. That would depend on the type of glaucoma.
Q. Angle closure glaucoma. Can that be managed at home?
A. No.
Q. Not via self-care; correct?
A. I don't know of any cases where that's

Page 100

happened.
Q. Okay. If you suspect a patient of angle closure glaucoma, do you -- what do you do? If you suspect a patient of angle closure glaucoma, and you're at the end of the appointment, what next?
MR. WHITE: Object to the form. Can you define what you mean by suspect? I mean, I think he's already said what he does when they determine they have glaucoma.
Q. All right. If you are of the opinion that they may have angle closure glaucoma, and you're at the end of the appointment, what do you do?
A. I'm going to walk in and pick up the phone and call Medical Arts and ask them if he can go over there and let them look at him.
Q. Okay. And that's because you understand that angle closure glaucoma is a medical emergency, correct?
A. Correct.

Page 73

and symptom of glaucoma, correct?
A. Uh-huh (positive response).
Q. Is that a yes?
A. I don't see that very much. It can be.
Q. It can be. All right. So you've stated glaucoma is a serious eye disease that can cause blindness, correct?
A. Correct.
Q. Okay. So is glaucoma something that you would want to rule out for a patient presenting with seeing halos around lights?
A. Correct.
Q. And would ruling out glaucoma involve doing more than one method of tonometry?
A. It would depend on the reading that I got on the first type. It would depend on the appearance of the optic nerve head. It would depend on whether they have other problems like a cataract or corneal scarring or other problems. How open their anterior chamber angle is. That's not something that you could say for

Page 74

everybody.
Q. Okay. If a patient presented with seeing halos around lights and pain, headaches, what would you be concerned with?
A. I don't think you could tell -- you couldn't say anything that -- the same shoe doesn't fit everybody. You can't say what you would do without having an individual there with more input, information than what you're giving me.
Q. And the way you get more input and information is to conduct testing; is that correct?
A. That's correct.
Q. Okay.
A. And ask questions.
Q. Under what circumstances would you refer a patient like that to an ophthalmologist?
A. If there were enough findings that were positive that that patient might have glaucoma, then I would refer them to an ophthalmologist.
Q. Have you ever referred a patient to an

Page 75

ophthalmologist?
A. Just every day, yes.
Q. Okay. And that's because you want to prevent serious eye problems; is that correct?
A. That's correct.
Q. And that's because you recognize that while you are an individual, as you testified earlier, trained to examine eyes, you understand that there are things that an ophthalmologist is trained to do that you are not qualified or trained to do; is that correct?
A. That's correct.
Q. Is there any treatment for glaucoma that an ophthalmologist is able to providea patient that you are not able to provide a patient?
A. Yes.
Q. Okay. Tell me about that.
A. Any surgical procedure that would be indicated.
Q. And what surgeries are used to correct

Page 76

glaucoma and intraocular pressure?
MR. WHITE: Object to the form. You're asking about what an ophthalmologist does, and I don't know that he's qualified to answer these questions. If you're just asking him if he knows, I guess he can answer.
MR. ADAMS: Sure. You're right.
Q. Do you know?
A. I have no reservation about answering that, and it would not be any one thing for any one patient. It would depend on the particular patient.
Q. Okay. But do you agree that surgery is sometimes necessary to correct glaucoma?
A. Yes.
Q. Okay. Where it says tonometry or other appropriate glaucoma testing, what other testing is appropriate to detect glaucoma?
A. Probably -- well, there's several mainstays on that. Okay. One is the pressure in your eye, okay, and looking at the optic

Page 121

A. Yes.
Q. Do you believe that he is referring to puff test tonometry or to applanation or Goldmann tonometry?
MR. WHITE: Object to the form.
Q. Based on your familiarity with the accepted form and best form of tonometry, what do you think is suggested there?
MR. WHITE: Object to the form.
MR. ADAMS: He'san optometrist. He can testify.
MR. WHITE: You're asking him to read into what he's saying and guess at what his true intent was? That's ridiculous.
MR. ADAMS: No, it's not.
MR. WHITE: It's absurd is what it is.
MR. ADAMS: No. You do your homework, and you'll find out, it's not absurd.
MR. WHITE: This man didn't do his homework? That's what you're

Page 122

saying? The author of this book didn't do his homework?
MR. ADAMS: You may not understand the question. Let me rephrase it.
Q. In the most current literature, where you see the word tonometry, is that in reference to puff test or to Goldmann tonometry?
A. I really --
MR. WHITE: Object to the form.
A. I really couldn't say unless they specified on there.
Q. Okay. You agree that visual field testing is a necessary clinical exam for somebody with the symptoms of angle closure glaucoma?
A. I think that if somebody has angle closure glaucoma that I'm going to send them to the ophthalmology clinic, and they're going to discern which tests need to be run on that patient.
Q. Okay. How are you going to determine

Page 123

whether their angle is closed?
A. By looking with the slit lamp.
Q. But you testified earlier that a gonioscopy is --
A. And I was going to say, and if it appears to be narrow with the slit lamp, I'm going to do gonioscopy.
Q. Okay. And earlier I asked you did you believe that the writers of this text were wrong to state that a gonioscopy must be one of the tests, and I'm not sure I understood your answer. Is the gonioscopy a necessary test for someone having these symptoms?
A. What was the pressure?
Q. We're not talking about pressure, as I understand it. We're talking about these symptoms. If they present with these symptoms, one of these symptoms, one or more of these symptoms, is a gonioscopy required?
A. It would depend on what other things I did and what symptoms would apply to any other

Page 124

problems that I had found or did not find on that patient.
Q. Okay. So if I understand you correctly, you are -- do I understand you correctly to disagree with the writers of this text that gonioscopy must be a test performed when a patient presents with these symptoms?
MR. WHITE: Objection to the form of that. You're paraphrasing something that the book doesn't say.
A. It doesn't say that in the book.
Q. Well, actually, what it says is the clinical examination for both conditions, referring to both types of angle closure glaucoma, consist. It consists. It will include gonioscopy.
A. That's correct.
Q. And you will agree with that?
A. If they have it.
Q. If they have these symptoms.
A. No, that's not what it says.
MR. WHITE: We're going to have to

Page 117

A. Correct.
Q. You agree that if it's not managed appropriately, possible acute attacks could occur in the future, correct?
A. That's a possibility.
Q. Okay. You agree that the signs and symptoms of angle closure glaucoma include red eye? Do you agree with that? I believe you've already testified to that.
A. If the angle is closed when they come in the office, their vessels will be dilated.
Q. Okay. And that results in red eye, correct?
A. Correct.
Q. You agree that one of the symptoms of angle closure glaucoma is blurred vision, correct?
A. Yes, it can -- that could be one of the symptoms.
Q. Okay. And you agree that colored rings around lights is one of the symptoms, correct?
A. It can be the symptom of this.

Page 118

Q. All right. And another way of saying colored rings around lights is halos, correct?
A. I guess you would have to ask the patient what they meant by that to verify that.
Q. All right. Further, you agree tearing can be a symptom of angle closure glaucoma?
A. Correct.
Q. Ocular discomfort can be a symptom?
A. Yes.
Q. And headache can be a symptom?
A. Some -- yes.
Q. Okay.
A. It can be.
Q. All right. Let's move down to the third paragraph. You see where it says, the clinical examination for both conditions consists of history, biomicroscopy, gonioscopy, optic disk evaluation, tonometry, and visual field testing. Did I read that correctly?
A. Yes.
Q. Do you agree that an accurate and thorough

Page 119

taking of the patient's history is necessary to examine for angle closure glaucoma?
A. I didn't catch the first part. You said something about history.
Q. All right. Do you agree that an accurate and thorough taking of the patient's history is necessary to examine for angle closure glaucoma?
A. Yes.
Q. And you agree that the same is true of biomicroscopy?
A. That's something that should be done on every patient.
Q. Okay. So that's a yes?
A. Uh-huh (positive response).
Q. That was a yes?
A. Yes.
Q. Okay. And do you agree that gonioscopy is necessary in order to do an appropriate clinical examination for angle closure glaucoma?
A. It's one of the tests that can be done for

Page 120

that. I mentioned earlier a couple of other tests that can also be done for that.
Q. Okay. But are you prepared to say that Dr. Bartlett should not have included this in his list of necessary examinations?
A. I think that gonioscopy -- let's see how he words this. I don't even -- let's see. What's the year on this?
Q. It's 2001.
A. Seems like some of the other instruments that I mentioned to you were not even available at the time this book was printed.
Q. Okay. And do you use any of those instruments to view the angle of the eye?
A. I have a gonioscope. I don't have one of the OHT instruments.
Q. And you had a gonioscope in 2004?
A. I did.
Q. All right. Do you agree that optic disk evaluation is necessary?
A. Yes.
Q. Do you agree that tonometry is necessary?

Page 189

something that – another incident that causes damage to the optic nerve. You could have hyphema, which is the leakage of a blood vessel in the back of your eye that can be secondary to diabetes or a list of other general health problems.

You want me to keep going?

Q. Yeah.

A. Okay. You could have what's known as iritis, which is an inflammatory problem.

You know, I'd have to have something to write with and write all these down so I'm not repeating myself on all of them.

Q. You testified earlier you agree that seeing halos around lights is a symptom of angle closure glaucoma, correct?

A. Yes.

Q. Okay. The two of those coupled together –

A. I'm sorry. Which two are we talking about?

Q. The blurry vision or film over the eye together with the halos around lights. Would you agree that that should cause some concern for an optometrist that Kyle may

Page 190

have -- or that this patient, a patient presenting with this could have angle closure glaucoma?

A. That would be a possibility, and it would be a very low chance.

Q. But because it's a possibility and because glaucoma is so dangerous and can result in blindness, it is something you would want to eliminate?

A. Right.

Q. Okay. And therefore, you would want to conduct a thorough examination of the patient's angles, correct?

A. That is -- that does not define him as having glaucoma or not. That only defines the appearance of the angle. There were tests done: Measuring the pressure in his eye, looking at the optic nerve, checking the pupillary actions, doing a screening for angle closure with the slit lamp. All of those were testing to see if he showed any other signs or symptoms of glaucoma.

Q. Okay. But I believe your testimony earlier

Page 191

was that the gonioscopy presents a better view of the angle; is that correct?

A. Right. That's correct.

Q. Okay. Why did you not use the gonioscopy to get the best possible view of the angle?

A. Because there was no indication to do that. All the other findings to rule out glaucoma were okay.

Q. What other findings?

A. I just went through them. It had to do with the pressure in his eye. It had to do with the appearance of his optic nerve. It has to do with the clarity of his cornea. Has to do with -- we've already screened to see if his angle was open with the slit lamp exam, and all of those findings were normal.

Q. Are you aware as to whether the NCT tonometry was the preferred tonometry test at the time of this visit?

MR. WHITE: Object to the form.

A. Could you rephrase that another way for me?

Q. Well, let's kind of back up. On one of his

Page 192

prior visits, the October 2001 visit, you had had a problem with the NCT tonometry, correct?

MR. WHITE: Object to the form. I don't believe that's what he testified to.

Q. Well, you had had to do another type of tonometry, correct?

A. I didn't have to. I wanted to.

Q. And you testified you wanted to because you believed Kyle was squinting his eyes or squeezing his lids together?

A. That's what was written on the chart, yes.

Q. And is that sometimes a problem with the NCT tonometry?

A. Yes.

Q. And the NCT tonometry is a less accurate test because patients often do that, correct?

A. They don't often do it.

Q. Well, they sometimes do it, right?

A. Uh-huh (positive response).

Q. Yes?

Page 209

Q. Or the origin of the symptoms, correct?
A. The origin of the symptoms, I'm not sure -- you would have to be more specific than that.
Q. Yeah, you're right. That's not a real good question.
It doesn't matter -- your duty doesn't change if somebody comes in with glaucoma pursuant to an injury or glaucoma pursuant to some other cause, does it? Your duty to provide good care is the same, correct?
A. My duty is to try to figure out if they do have glaucoma, and if they do, then to try to get something done about it.
Q. Whether or not that glaucoma originates from an injury or some other cause, right?
A. That's true.
Q. Okay. How could the gonioscopy have aided in the diagnosis of narrow angle glaucoma in Kyle Bengtson?
MR. WHITE: Object to the form.
A. Somebody who actually saw him when he had angle closure glaucoma would be better able

Page 210

to answer that question. I don't know exactly what was going on with him at that time. It wasn't doing that when I saw him.
Q. Okay. Whether or not he had a closed angle at the time he came to see you, based on his complaint that he was seeing halos around lights, why was the gonioscopy not performed?
A. There was no indication to perform it.
Q. Would Goldmann tonometry have aided you in your diagnosis?
A. No more so than what we had already.
Q. And are Goldmann tonometry and applanation tonometry the same thing?
A. There are other kinds of applanation tonometry.
Q. I'm just going to show you this. We may make it an exhibit, but -- I'll show it to your attorney. That's just something I found on the internet, and I'll be glad to share a copy with your lawyer if you want to. This is just something that --
MR. WHITE: You want him to read

Page 211

it?
MR. ADAMS: I'm just going to ask him about it.
MR. WHITE: He needs to read it first.
Q. Well, you can read it. Sure. No problem.
MR. WHITE: Well, and we're not going to answer questions about it unless you're going to make it an exhibit to the deposition.
MR. ADAMS: That's fine. I'll make it an exhibit. That's fine.
(Plaintiff's Exhibit 6 was marked for identification.)
Q. I'm just going to ask you about the middle paragraph there on the symptoms.
MR. WHITE: I don't think he's finished reading it. I know I'm not. We just finished the first paragraph.
MR. ADAMS: All right.

Page 212

Q. Okay. If you don't mind, just put this down on the table where we can both look at it.
A. Okay.
Q. All right. Where it says symptoms of narrow angle glaucoma, you agree with me that it says cloudy cornea there?
A. Correct.
Q. Blurring and decreased visual acuity. Do you see that?
A. Correct.
Q. Seeing halos around lights. Do you see that?
A. Well, I saw it, yes.
Q. All right. Are you aware that this kind of information -- I'll just represent to you that this kind of information regarding the signs and symptoms of angle closure glaucoma is readily available to a layman over the internet. Are you aware of that?
A. I would think probably so.
Q. Okay.
A. If they looked under -- you could do it

Page 113

patient would have to have all of these symptoms for the clinical examination -- for it to be required that the clinical examination include history taking, biomicroscopy, gonioscopy and tonometry?
A. Correct.
Q. Okay. Let's look at the next page, if you would, page 866. I'd like you to look at the second full sentence on that page. Do you see where it says there, is often a history of mild attacks?
A. Second -- oh, okay. You're starting down here.
That would be what he has in the book.
Q. Okay. Do you agree that a history of mild attacks can accompany someone who has acute angle closure glaucoma?
A. Often is sort of a wide-open word. My experiences with the angle closures that I have dealt with are that they are an acute problem that they come in the office with, and that's not usually -- prior history is not usually positive.

Page 114

Q. Okay. But do you agree it is possible that they could come into the office without the symptoms at that moment, but give a history of mild attacks, and that that -- that that history would necessitate you testing for acute angle closure glaucoma?
A. I can't answer that the way you're putting it.
Q. Okay. Well, let's see --
A. There are more specifics to the case.
Q. Let's see if I can do better. Do you agree that just because someone doesn't have high intraocular pressure as they sit under an exam at your office, that does not necessarily mean that they do not have angle closure glaucoma?
A. Again, that would be a case-by-case thing. You couldn't make a blanket statement about it.
Q. Is it possible?
A. It's possible, yes.
Q. And even though somebody doesn't have high intraocular pressure at the time they sit

Page 115

for an exam in your office, that does not mean that you shouldn't rule out the possibility of angle closure glaucoma through other testing, correct?
A. Angle closure glaucoma is ruled out on every patient that comes in for an exam, whether they have symptoms of it or not.
Q. Okay. And that is because angle closure glaucoma can result in blindness, correct?
MR. WHITE: Object to the form. Asked and answered.
Q. Is that correct?
A. I'm sorry. What? What was the question?
Q. That's fine. He's right. You have already affirmatively answered that.
All right. Let's look at page 869. All right. You see the section there that says, subacute and chronic angle closure glaucoma. You see that section?
A. Yes.
Q. It says, diagnosis. Okay. And I'm just going to read part of that first paragraph: A subacute angle closure attack

Page 116

requires prompt diagnosis and appropriate management in part to avoid a possible acute attack in the future. The symptoms, although transient, are similar to those in acute angle closure glaucoma and include red eye, blurred vision, colored rings around lights, tearing, ocular discomfort, and headache located above the eye.
Did I read that correctly?
A. Yes.
Q. Okay. And do you agree that -- do you agree with what I just read?
MR. WHITE: Agree that you just read it correctly?
Q. Do you agree that what I just read is accurate?
A. It would apply in some instances.
Q. Okay. Let's break it down. You agree that subacute angle closure glaucoma requires prompt diagnosis, correct?
A. Hopefully, it would.
Q. You agree that it requires appropriate management, correct?

Page 53

optometric visit. Is that a fair definition?
A. There is no minimum things that should be done at every office visit that comes in. It would vary depending upon the patient's needs.
Q. Well, I'll tell you what. I don't know why, but it seems like we're having trouble with this, so let me just -- I'm going to read this into the record, and you tell me if I read anything wrong. Okay?
630-X-12-.06, failure to meet standard of care. The board shall consider it unprofessional conduct for a licensee to provide for a patient care that is less than the generally accepted standard of care. This standard of care shall include but not be limited to providing certain minimum testing for the patient when performing a comprehensive eye exam. A comprehensive eye exam shall include any examination wherein a prescription for glasses or contact lenses or necessity

Page 54

thereof is determined. Minimum testing for a comprehensive eye exam shall include a case history, determination of refractive error, binocular vision evaluation, ophthalmoscopy, evaluation of health of external eye and adjacent structures, tonometry or other appropriate glaucoma testing, and such other tests as are necessary under the circumstances. Failure to perform said minimum testing during a comprehensive eye exam shall constitute failure to meet the standard of care.
Did I read this paragraph correctly?
A. I thought so, yes.
Q. Okay. I didn't misstate anything?
A. No.
Q. All right. And do you agree that this is the minimum that an optometrist should do?
A. For a comprehensive eye exam?
Q. Yes.
A. I would agree with that.
Q. Okay. So you agree that minimum testing for a comprehensive eye exam must include a

Page 55

case history?
A. Yes.
Q. Okay. And it must include a determination of refractive error?
A. Yes.
Q. All right. Let's back up. How do you go about getting a case history?
A. It depends on whether it's a new patient or a former patient. New patients are asked to fill out some questions, answer some questions that are on the registration form, and all of the patients, whether they're old or new patients, are given an oral case history.
Q. Okay. And do you ask questions of the patients?
A. Yes, I do.
Q. Okay. What questions do you ask?
A. Is this a new patient or an old patient?
Q. Well, let's take a new patient first.
A. Okay. The questions that they're asked to fill in on the sheet are whether -- well, there's several questions on there. I

Page 56

don't have one in front of me. But basically, I'm going to go back through those questions and ask them if there was any -- if there were yeses and nos on that, then I'm going to explore the yeses and see what's going on there. Then I will also ask them some other questions under an oral history and write them down on the actual front exam area of the medical record.
Q. All right. And what questions do you ask them on the oral history?
A. They're asked if they have been in before, and if so, how long it has been. They are asked why they're there today. Was it time for a routine exam, or are they having problems? If so, what kind of problem are they having? They're asked if they're on any medicine for anything or have any general health problems or if they're allergic to any medicine. They're asked if they've ever had any operations or injuries or infections or surgery on their eyes. They're asked if there's any family history

Page 125

agree to disagree over what it says.
Q. All right. Do you agree that the use of a gonioscopy better allows you to view the angle of the eye?
A. Well, what do you --
MR. WHITE: Object to the form.
A. We've covered this one before, too. I told you there were three main things. One was with the slit lamp, one was gonioscopy, and one was the OHT instrument.
Q. Of the three, which allows you to view the angle of the eye the best?
A. I would say the OHT instrument.
Q. Okay. And then what is the second best?
A. The gonioscopy.
Q. You've testified earlier that glaucoma is a serious medical condition that can result in blindness, correct?
MR. WHITE: Object to the form.
Asked and answered.
Q. You haven't changed your mind on that, have you?

Page 126

A. No.
Q. Okay. And that is something that you need as an optometrist to rule out when you see a patient who has some symptoms of glaucoma, correct? You need to rule out glaucoma, correct?
A. I need to rule out glaucoma, yes.
Q. Okay. And in order to do that, you need to view the angle of the eye, correct?
A. Not necessarily.
Q. All right. I'd like you to look at the first full paragraph in the next column. Do you see where it says, evaluation of the anterior chamber angle is best accomplished by gonioscopy? Do you see that?
A. I do.
Q. Do you agree with that?
A. Just a minute ago, we talked about the three most commonly used ways of doing that. And like I said, when the book was written, they didn't have some of the instruments available then that -- so this book is not -- it's outdated.

Page 127

Q. All right. But, now, did you have -- What did you call it, the OHD?
A. OHT. I'm not even -- that is an instrument that has only come out here in the last year or two, so I don't even know if he has one up there or not.
Q. So you didn't have an OHT in 2004?
A. No.
Q. All right. But you've already testified you had a gonioscopy in 2004?
A. Right.
Q. Okay. Do you agree with that statement, not -- Let's forget about the OHT for a moment. Between the other available methods of viewing the angle, do you agree that the gonioscopy is the better method than the slit lamp?
A. Right. Then the von Herrick screening method. Both of them require the slit lamp.
Q. Okay. All right. Next paragraph. It says, even when the anterior chamber angle is assessed as being narrow or even

Page 128

dangerously narrow, further information is often needed.
Do you agree with that?
A. I just have to have a minute to read what's there besides that one sentence, because that's not all that's involved with it.
Q. Well, take your time.
A. Okay. Now go ahead and ask me again, please.
Q. All right. When the anterior chamber is assessed as being narrow or even dangerously narrow, further information is needed, right? Do you agree with that?
A. Further information before you do what?
Q. Well, let me just ask you. If you see a very narrow angle, may not be closed but it's narrow, what do you do?
A. I am probably going to have that go to Medical Arts to see if they want to do a prophylactic laser procedure on that.
Q. And why is that?
A. Because I'm not allowed to do that procedure? Is that what you're asking?

Page 129

Q. No, sir. I'm asking, what are you concerned about that would motivate you to send them to Medical Arts?
A. That their angle didn't close off and the pressure go up and they have nerve damage.
Q. All right. Have you ever done a pressure gonioscopy?
A. Yes.
Q. All right. Is that something that was available to you in 2004?
A. Yes.
Q. Okay. All right. I'd like you to turn to page 870, please, where it says management. You see -- I'll read it: Surgical intervention should be considered for all eyes with subacute angle closure glaucoma.
Do you see that?
A. Correct.
Q. And that involves referral to an ophthalmologist, correct?
A. It also had some other stuff after that.
Q. Okay. Do you want to talk about the other

Page 130

stuff?
MR. WHITE: Well, I think his point is you can't just take one --
A. Out of context.
MR. WHITE: -- sentence and take it out of context. I mean --
MR. ADAMS: Well, I think that's a pretty straightforward sentence. No conditions in that sentence.
MR. WHITE: Well, it's under management, and it's talking about all different kinds of management. So -- I don't know what would -- I mean, I think we can agree those words are written in this book.
Q. All right. Do you agree that if a patient has subacute angle closure glaucoma that surgical intervention should be considered?
A. That patient would be referred to Medical Arts, and it would be up to them, not to

Page 131

me, whether they had surgery or not.
Q. Correct. So if somebody has subacute angle closure glaucoma, they should be referred to an ophthalmologist. Do you agree with that?
It's not in the book. I just said it.
A. I'm just trying to look at where you're taking this sentence out of again.
Okay. Now if you'll ask me that again, please.
Q. If a patient has subacute angle closure glaucoma, they should be referred to an ophthalmologist, correct?
A. Yes.
Q. Okay. All right.
MR. ADAMS: Do you want to take a snack break?
MR. WHITE: Yeah. What time is it?
(Brief lunch recess.)
Q. (Mr. Adams continuing) Dr. Bazemore, as far as documentation goes, can you tell me why you document the treatments given?

Page 132

A. I'm sorry. You asked why do I document?
Q. Yes.
A. So next time I'll know what I did the time before.
Q. Okay. And why is that important?
A. Well, number one, it will help me understand, if the patient is in the office with a problem, whether it's a new or an old problem; whether there have been changes since that time or not.
Q. And do you document everything or just some of what you do?
Let me back up. That's kind of a bad question.
A. You'll have to be more specific.
Q. If you perform a test or an exam, are you going to document in some way that you did that test or exam?
A. There are certain exams that you would document by not writing anything down that was a result of the test other than that you did it, and that would be that it was normal.

Page 93

can vary, correct?
A. If the angle is closed, then the pressure will be elevated.
Q. Does the angle -- with angle closure glaucoma, is the angle always closed?
A. There are different kinds of angle closure glaucoma.
Q. Okay. And what are the kinds of angle closure glaucoma?
A. You can have a primary kind, you can have a secondary kind, and the secondary kind would be due to various things.
Q. Okay. What is primary?
A. The angle just closes off because of the anatomical shape of the person's anterior chamber angle.
Q. All right. What is secondary?
A. It has several different reasons that that could happen.
Q. Okay. Can you give me some of them?
A. They could have pigmentary glaucoma where it's clogging the trabecular meshwork. They could have an angle recession where

Page 94

there's damage to the trabecular meshwork. There are others that we can look up if you want to.
Q. Well, I'm just asking you the ones you remember as you sit here right now.
A. Right.
Q. Is that all of them?
A. You can have -- anything that got inside your eye, if you had trauma to your eye, and it -- there are other iris and corneal degenerative conditions that release cells that clog up the trabecular meshwork.
Q. When is glaucoma an emergency?
A. If they came in and the pressure is very high, then I'm going to pick up the phone and call the ophthalmology office and they're going over there then.
Q. Okay. And what if they come in and they -- their history is that they're having some signs and symptoms of glaucoma, but their pressure is not high? What do you do for that kind of patient? It's not high at that visit.

Page 95

A. I couldn't say. It would depend on other things about the patient.
Q. Okay. But would you still want to run tests for glaucoma if their history --
A. Every patient that comes in gets tested for glaucoma.
Q. How is angle closure glaucoma managed?
A. That would vary from case to case. I couldn't say.
Q. All right. Well, just say primary angle closure glaucoma. How do you manage that?
A. It depends on the elevation of the pressure, and I don't manage that. That's up to the ophthalmologist.
Q. You would send that person to an ophthalmologist?
A. Yes.
Q. What about secondary angle closure glaucoma? How is that managed?
A. If the pressure is elevated, it goes to the ophthalmologist.
Q. And what if the pressure is not elevated at that particular time?

Page 96

A. And what other signs make you think that they have glaucoma at that point?
Q. Well, I'm -- that's a good question. What other signs would there be that would make you be concerned about glaucoma?
A. Well, there's a lot of them, you know. We've been through this. But if their optic nerve head shows damage, if their cornea shows damage from the pressure being too high and other things like that that you have to look for as well as just the pressure.
Q. All right. Well, you've testified earlier that with angle closure glaucoma, there is a type of angle closure glaucoma where the pressure is not constantly elevated, correct?
A. That's right.
Q. All right. Would that be what's called acute angle closure glaucoma?
A. It would depend on whose book you were reading. The terms primary and secondary include that secondary are due to other

Page 125

agree to disagree over what it says.
Q. All right. Do you agree that the use of a gonioscopy better allows you to view the angle of the eye?
A. Well, what do you --
MR. WHITE: Object to the form.
A. We've covered this one before, too. I told you there were three main things. One was with the slit lamp, one was gonioscopy, and one was the OHT instrument.
Q. Of the three, which allows you to view the angle of the eye the best?
A. I would say the OHT instrument.
Q. Okay. And then what is the second best?
A. The gonioscopy.
Q. You've testified earlier that glaucoma is a serious medical condition that can result in blindness, correct?
MR. WHITE: Object to the form. Asked and answered.
Q. You haven't changed your mind on that, have you?

Page 126

A. No.
Q. Okay. And that is something that you need as an optometrist to rule out when you see a patient who has some symptoms of glaucoma, correct? You need to rule out glaucoma, correct?
A. I need to rule out glaucoma, yes.
Q. Okay. And in order to do that, you need to view the angle of the eye, correct?
A. Not necessarily.
Q. All right. I'd like you to look at the first full paragraph in the next column. Do you see where it says, evaluation of the anterior chamber angle is best accomplished by gonioscopy? Do you see that?
A. I do.
Q. Do you agree with that?
A. Just a minute ago, we talked about the three most commonly used ways of doing that. And like I said, when the book was written, they didn't have some of the instruments available then that -- so this book is not -- it's outdated.

Page 127

Q. All right. But, now, did you have -- What did you call it, the OHD?
A. OHT. I'm not even -- that is an instrument that has only come out here in the last year or two, so I don't even know if he has one up there or not.
Q. So you didn't have an OHT in 2004?
A. No.
Q. All right. But you've already testified you had a gonioscopy in 2004?
A. Right.
Q. Okay. Do you agree with that statement, not -- Let's forget about the OHT for a moment. Between the other available methods of viewing the angle, do you agree that the gonioscopy is the better method than the slit lamp?
A. Right. Then the von Herrick screening method. Both of them require the slit lamp.
Q. Okay. All right. Next paragraph. It says, even when the anterior chamber angle is assessed as being narrow or even

Page 128

dangerously narrow, further information is often needed.
Do you agree with that?
A. I just have to have a minute to read what's there besides that one sentence, because that's not all that's involved with it.
Q. Well, take your time.
A. Okay. Now go ahead and ask me again, please.
Q. All right. When the anterior chamber is assessed as being narrow or even dangerously narrow, further information is needed, right? Do you agree with that?
A. Further information before you do what?
Q. Well, let me just ask you. If you see a very narrow angle, may not be closed but it's narrow, what do you do?
A. I am probably going to have that go to Medical Arts to see if they want to do a prophylactic laser procedure on that.
Q. And why is that?
A. Because I'm not allowed to do that procedure? Is that what you're asking?

Page 97

secondary causes. Acute just means that the pressure is real high.
Q. Well, let me ask you this. What type of glaucoma are you talking about when you say that -- when you say that there is a type of glaucoma where the pressure is not constantly high, it can come and go? What type of glaucoma is that?
A. That would usually -- it kind of depends on -- like I said earlier, there's variation in the pressure anyway. But if you have something -- if you're on certain medications that might cause your pupil to be dilated versus not dilated or if you have some -- well, there's a lot of things. I just really couldn't answer that for a blanket statement.
Q. All right. You have stated, again, that there is a type of angle closure glaucoma where the pressure is not constantly elevated, correct?
A. That's my understanding.
Q. Okay. If a patient presents in your office

Page 98

with signs and symptoms of glaucoma but not at that particular time elevated pressure, what do you do for that patient?
A. Again, it would depend on what other signs and symptoms there were. Okay? And the decision of when to have them back and check for this or that would depend on the other signs and symptoms if the pressure is normal.
Q. All right. Well, what if that sign and symptom --
I'm sorry. Did I cut you off?
A. Well, I'm just -- you know, I don't know if the pressure -- Well, that's all I know to say.
Q. What if the other signs and symptoms are -- include headaches and seeing halos around lights and blurry vision, but the pressure is not high at that particular time? What would you do for that patient?
A. Was this a new patient that I've never seen before?
Q. Let's take both situations. New patient

Page 99

you've never seen before.
A. Okay.
Q. What would you do?
A. I would first of all see what other things might be wrong that would cause the symptoms that you're talking about. Those are not limited to having glaucoma. In fact, that would be down the list of causes for those symptoms. It would be more common for them to have some other problems that would cause that.
If I had seen them before, then what I did or didn't do would be based on whether there was continuity from the times before, whether something was changing.
Q. Okay. Can glaucoma be managed via self-care at home?
A. That would depend on the type of glaucoma.
Q. Angle closure glaucoma. Can that be managed at home?
A. No.
Q. Not via self-care; correct?
A. I don't know of any cases where that's

Page 100

happened.
Q. Okay. If you suspect a patient of angle closure glaucoma, do you -- what do you do? If you suspect a patient of angle closure glaucoma, and you're at the end of the appointment, what next?
MR. WHITE: Object to the form. Can you define what you mean by suspect? I mean, I think he's already said what he does when they determine they have glaucoma.
Q. All right. If you are of the opinion that they may have angle closure glaucoma, and you're at the end of the appointment, what do you do?
A. I'm going to walk in and pick up the phone and call Medical Arts and ask them if he can go over there and let them look at him.
Q. Okay. And that's because you understand that angle closure glaucoma is a medical emergency, correct?
A. Correct.

Page 73

and symptom of glaucoma, correct?
A. Uh-huh (positive response).
Q. Is that a yes?
A. I don't see that very much. It can be.
Q. It can be. All right. So you've stated glaucoma is a serious eye disease that can cause blindness, correct?
A. Correct.
Q. Okay. So is glaucoma something that you would want to rule out for a patient presenting with seeing halos around lights?
A. Correct.
Q. And would ruling out glaucoma involve doing more than one method of tonometry?
A. It would depend on the reading that I got on the first type. It would depend on the appearance of the optic nerve head. It would depend on whether they have other problems like a cataract or corneal scarring or other problems. How open their anterior chamber angle is. That's not something that you could say for

Page 74

everybody.
Q. Okay. If a patient presented with seeing halos around lights and pain, headaches, what would you be concerned with?
A. I don't think you could tell -- you couldn't say anything that -- the same shoe doesn't fit everybody. You can't say what you would do without having an individual there with more input, information than what you're giving me.
Q. And the way you get more input and information is to conduct testing; is that correct?
A. That's correct.
Q. Okay.
A. And ask questions.
Q. Under what circumstances would you refer a patient like that to an ophthalmologist?
A. If there were enough findings that were positive that that patient might have glaucoma, then I would refer them to an ophthalmologist.
Q. Have you ever referred a patient to an

Page 75

ophthalmologist?
A. Just every day, yes.
Q. Okay. And that's because you want to prevent serious eye problems; is that correct?
A. That's correct.
Q. And that's because you recognize that while you are an individual, as you testified earlier, trained to examine eyes, you understand that there are things that an ophthalmologist is trained to do that you are not qualified or trained to do; is that correct?
A. That's correct.
Q. Is there any treatment for glaucoma that an ophthalmologist is able to providea patient that you are not able to provide a patient?
A. Yes.
Q. Okay. Tell me about that.
A. Any surgical procedure that would be indicated.
Q. And what surgeries are used to correct

Page 76

glaucoma and intraocular pressure?
MR. WHITE: Object to the form. You're asking about what an ophthalmologist does, and I don't know that he's qualified to answer these questions. If you're just asking him if he knows, I guess he can answer.
MR. ADAMS: Sure. You're right.
Q. Do you know?
A. I have no reservation about answering that, and it would not be any one thing for any one patient. It would depend on the particular patient.
Q. Okay. But do you agree that surgery is sometimes necessary to correct glaucoma?
A. Yes.
Q. Okay. Where it says tonometry or other appropriate glaucoma testing, what other testing is appropriate to detect glaucoma?
A. Probably -- well, there's several mainstays on that. Okay. One is the pressure in your eye, okay, and looking at the optic

Page 121

A. Yes.
Q. Do you believe that he is referring to puff test tonometry or to applanation or Goldmann tonometry?
MR. WHITE: Object to the form.
Q. Based on your familiarity with the accepted form and best form of tonometry, what do you think is suggested there?
MR. WHITE: Object to the form.
MR. ADAMS: He'san optometrist. He can testify.
MR. WHITE: You're asking him to read into what he's saying and guess at what his true intent was? That's ridiculous.
MR. ADAMS: No, it's not.
MR. WHITE: It's absurd is what it is.
MR. ADAMS: No. You do your homework, and you'll find out, it's not absurd.
MR. WHITE: This man didn't do his homework? That's what you're

Page 122

saying? The author of this book didn't do his homework?
MR. ADAMS: You may not understand the question. Let me rephrase it.
Q. In the most current literature, where you see the word tonometry, is that in reference to puff test or to Goldmann tonometry?
A. I really --
MR. WHITE: Object to the form.
A. I really couldn't say unless they specified on there.
Q. Okay. You agree that visual field testing is a necessary clinical exam for somebody with the symptoms of angle closure glaucoma?
A. I think that if somebody has angle closure glaucoma that I'm going to send them to the ophthalmology clinic, and they're going to discern which tests need to be run on that patient.
Q. Okay. How are you going to determine

Page 123

whether their angle is closed?
A. By looking with the slit lamp.
Q. But you testified earlier that a gonioscopy is --
A. And I was going to say, and if it appears to be narrow with the slit lamp, I'm going to do gonioscopy.
Q. Okay. And earlier I asked you did you believe that the writers of this text were wrong to state that a gonioscopy must be one of the tests, and I'm not sure I understood your answer. Is the gonioscopy a necessary test for someone having these symptoms?
A. What was the pressure?
Q. We're not talking about pressure, as I understand it. We're talking about these symptoms. If they present with these symptoms, one of these symptoms, one or more of these symptoms, is a gonioscopy required?
A. It would depend on what other things I did and what symptoms would apply to any other

Page 124

problems that I had found or did not find on that patient.
Q. Okay. So if I understand you correctly, you are -- do I understand you correctly to disagree with the writers of this text that gonioscopy must be a test performed when a patient presents with these symptoms?
MR. WHITE: Objection to the form of that. You're paraphrasing something that the book doesn't say.
A. It doesn't say that in the book.
Q. Well, actually, what it says is the clinical examination for both conditions, referring to both types of angle closure glaucoma, consist. It consists. It will include gonioscopy.
A. That's correct.
Q. And you will agree with that?
A. If they have it.
Q. If they have these symptoms.
A. No, that's not what it says.
MR. WHITE: We're going to have to

Page 173

at the deposition, I don't think I left the deposition with a copy of that exhibit.
MR. WHITE: That's fine.
MR. ADAMS: All right. Let's just press on, and then we'll talk about it.
MR. WHITE: We'll get it at the next break. I'll be glad to make you a clearer copy.
MR. ADAMS: All right.
Q. Let's go to the August 20th, 2004 office visit, please.
Under visual acuity, right eye, it looks like his vision has gotten worse; is that accurate? Am I reading that right?
A. Yes.
Q. It is accurate? Okay. It's now 20/100?
A. It has changed I thought was the question.
Q. I asked had it gotten worse.
A. Right.
Q. It has?
A. Yes.

Page 174

Q. All right. Interpret those numbers for me, please. Just tell me what all that means under visual acuity.
A. Okay. Again, uncorrected distance visual acuity is on the left-hand side of the sheet. The right eye was 20/100 and the left eye was 20/40. Then it has the correction for his last glasses prescription there, and then it has the last contact lens prescription next to it.
Q. Okay. Is there anything that you're concerned about when you see his right eye has gone from 20/50 to 20/100?
A. Well, it's obviously changed some, and we just have to find out what's caused it to do that.
Q. What could be the reasons for that?
A. Far and away the most common would be a change in his glasses prescription. He could have also had a cataract. He could have also had a corneal injury that left a scar. He could have a retinal problem. You know, a lot of things.

Page 175

Q. And could episodes of angle closure contribute to a loss of vision?
A. That would be very uncommon.
Q. Okay. I mean, but you testified several times that a closed angle, angle closure glaucoma can cause nerve damage, correct?
A. Correct.
Q. Okay. All right. So that can lead to a loss of vision?
A. Can nerve damage lead to a loss of vision? Is that what you're asking?
Q. Yes.
A. Yes.
Q. Okay. His last eye exam was -- you have September 27th, 2003, right? Is that what you've written there?
A. Uh-huh (positive response). Yes.
Q. And under chief complaint, what have you written, please?
A. We're going underneath there now?
Q. Yes.
A. Trouble with right eye. Has film over it and is worse at night. Sees halos around

Page 176

lights. And it's been that way for approximately two months with minor worsening.
Q. Okay. And then reason over here where it says --
A. Problem with right eye. And then something got blocked off on the edge. Feels like something -- feels -- has film over it.
Q. Okay. Is my copy any better?
A. There's a word right here. I can't tell what it is.
Q. Okay. Do you have any idea?
A. I would say that it's probably -- it looks like an H, and it has film, which was the word that he used that I put in parentheses on the other side.
Q. Okay. What is above the problem with right eye, where it says reason? What does that say?
A. Routine exam.
Q. All right. Now, why did you put routine exam?
A. Because it wasn't for anything other than a

Page 173

at the deposition, I don't think I left the deposition with a copy of that exhibit.
MR. WHITE: That's fine.
MR. ADAMS: All right. Let's just press on, and then we'll talk about it.
MR. WHITE: We'll get it at the next break. I'll be glad to make you a clearer copy.
MR. ADAMS: All right.
Q. Let's go to the August 20th, 2004 office visit, please.
Under visual acuity, right eye, it looks like his vision has gotten worse; is that accurate? Am I reading that right?
A. Yes.
Q. It is accurate? Okay. It's now 20/100?
A. It has changed I thought was the question.
Q. I asked had it gotten worse.
A. Right.
Q. It has?
A. Yes.

Page 174

Q. All right. Interpret those numbers for me, please. Just tell me what all that means under visual acuity.
A. Okay. Again, uncorrected distance visual acuity is on the left-hand side of the sheet. The right eye was 20/100 and the left eye was 20/40. Then it has the correction for his last glasses prescription there, and then it has the last contact lens prescription next to it.
Q. Okay. Is there anything that you're concerned about when you see his right eye has gone from 20/50 to 20/100?
A. Well, it's obviously changed some, and we just have to find out what's caused it to do that.
Q. What could be the reasons for that?
A. Far and away the most common would be a change in his glasses prescription. He could have also had a cataract. He could have also had a corneal injury that left a scar. He could have a retinal problem. You know, a lot of things.

Page 175

Q. And could episodes of angle closure contribute to a loss of vision?
A. That would be very uncommon.
Q. Okay. I mean, but you testified several times that a closed angle, angle closure glaucoma can cause nerve damage, correct?
A. Correct.
Q. Okay. All right. So that can lead to a loss of vision?
A. Can nerve damage lead to a loss of vision? Is that what you're asking?
Q. Yes.
A. Yes.
Q. Okay. His last eye exam was -- you have September 27th, 2003, right? Is that what you've written there?
A. Uh-huh (positive response). Yes.
Q. And under chief complaint, what have you written, please?
A. We're going underneath there now?
Q. Yes.
A. Trouble with right eye. Has film over it and is worse at night. Sees halos around

Page 176

lights. And it's been that way for approximately two months with minor worsening.
Q. Okay. And then reason over here where it says --
A. Problem with right eye. And then something got blocked off on the edge. Feels like something -- feels -- has film over it.
Q. Okay. Is my copy any better?
A. There's a word right here. I can't tell what it is.
Q. Okay. Do you have any idea?
A. I would say that it's probably -- it looks like an H, and it has film, which was the word that he used that I put in parentheses on the other side.
Q. Okay. What is above the problem with right eye, where it says reason? What does that say?
A. Routine exam.
Q. All right. Now, why did you put routine exam?
A. Because it wasn't for anything other than a

Page 181

A. So the right eye was seeing 20/25 plus two, and the left eye saw 20/20 minus one, which means that with the right eye, he got two right on the 20/20 line, and on the left eye he missed one on the 20/20 line.
Q. So how has his vision changed?
A. The correction for astigmatism has gone up a good bit in the right eye.
Q. Okay. And how would you describe his overall visual health at this point?
A. Health as in pathology or --
Q. I'll tell you what. Let's just strike that. We'll come back to it.
All right. Monocular and binocular.
A. That has to do with the type of cross-cylinder you use on the phoropter.
Q. PRA and NRA. What's that?
A. Same thing.
Q. Okay. And why didn't you do that, again?
A. Positive relative accommodation has to do with the type of -- when you go through and you adjust the lenses on the refractor, and -- all of these things, the monocular

Page 182

cross cylinder and the PRA and the NRA have to do mainly with things that are done on people whose vision does not correct well.
Q. Okay. And was there any reason to do any of those?
A. I did not feel it was indicated.
Q. All right. Why not?
A. There was no reason to do it. The monocular cross cylinder is done on everybody that has a glasses prescription.
Q. But he did have a glasses prescription.
A. Yeah, that's what I'm saying. All that -- the fact that this -- this is not something, you know -- this is something that's built into the instrument. Now, if you do a refraction with trial lenses, then you have to take a cross cylinder out of the drawer and hold it up and flip it and stuff. But every time you do a subjective refraction through a phoropter, it has a monocular cross cylinder.
Q. All right. So why didn't you do it?
A. It's automatically done.

Page 183

Q. All right. Well, why isn't it documented?
A. Well, because you can't choose. You do it if you use that instrument.
Q. Okay.
A. There was not -- it's done every time they come in and they are refracted through the phoropter.
Q. I don't understand why it's not written down.
A. Because anybody that understood how the subjective was done would know that that was used as part of the instrument to check that. So any other doctor that was looking would already know that if this test was done, it was done with that.
Q. Okay. Stereopsis. Was that done?
A. No.
Q. Okay. And, again, what is that test?
A. Depth perception?
Q. Color vision. What do you have written there?
A. He didn't miss any of those.
Q. And then to the right of that, what does it

Page 184

say?
A. Confrontation test where they do finger count and check the peripheral vision, and it was normal in both eyes.
Q. All right. And then keratometry. What do you have there?
A. Well, it just has the readings and the curvature on the front of the eye there, and that's the results of the test right there.
Q. Okay. And has that changed?
A. I expect so, because the correction for astigmatism changed. Let's see. I'm looking at 3/24/2000. If you want to look back there, the right eye, there's a difference between the left-hand number and the right-hand number. It was .37 then, and now it's 1.5. On the right eye it was .5, and now it's zero. The major difference is in the right eye where there's an increase in the curvature in one meridian versus the other, which is why the correction for astigmatism changed.

Page 185

Q. All right. And what do you have written to the right of there? What is that?
A. The M one percent OD and OS?
Q. What is that?
A. That's just the drop I put in to dilate his pupils.
Q. Okay. And then the slit lamp exam. What were the findings there?
A. It's one to three quarters, which is a grade four angle. Normal eyes and lids in both eyes.
Q. And then OPH. What is that?
A. Ophthalmoscopy, and it was normal also.
Q. Okay. And what does the ophthalmoscopy measure?
A. That looks into the back surface of your eye on the retina, or that's the major thing you're doing with it.
Q. Well, tell me what those markings are. I can't read your writing, so if you can just --
A. Oh. E3, which has to do with the category of the cupping in the optic nerve, the

Page 186

cup-to-disk ratio. And then it says SVP plus, which is spontaneous venous pulsation.
Q. Spontaneous what?
A. Venous pulsation. If you do not have a spontaneous venous pulsation, you have some circulatory problems.
Q. Okay. What was his spontaneous?
A. It was fine. It was SVP plus in both eyes.
Q. It looks like a 138 there. What is that?
MR. WHITE: Where are you looking at?
Q. In front of DS.
MR. WHITE: Point three five?
A. Point three five. I'm sorry. I didn't know what you were talking about.
Q. And then under that, what do you have written?
A. Fovea and general retinal area normal in both eyes.
Q. And then to the side of that, what is that?
A. Slit lamp -- oh, you're talking about over to the right-hand side?

Page 187

Q. Yes.
A. That's OU for both eyes.
Q. All right. Okay. So the NCT, what is that? I know what --
A. The reading? 13 and 12.
Q. At 10:20 in the morning?
A. Correct.
Q. And then what is your impression there?
A. Underneath? Is that what you're --
Q. Yes.
A. Compound myopic astigmat with change in the right eye. And that's -- it looks like it's change in the best corrected visual acuity in the right eye.
Q. And then your plan, what is that?
A. Change the right lens to the subjective reading up above after a positive demo of the change, which means that the patient was shown the new lens there in the chair in the office and thought that everything looked real good with that and wanted to change to that.
Q. Okay. And then under there it says right

Page 188

eye -- what, now?
A. That's the prescription for the glasses.
Q. And then you have recheck in one year?
A. Correct.
Q. Okay. You did not do Goldmann's tonometry, correct?
A. Not that visit, no.
Q. And you didn't do gonioscopy, correct?
A. No.
Q. All right. Do you agree that blurry vision is a symptom of angle closure glaucoma?
A. It is a symptom of angle closure glaucoma, but angle closure glaucoma is far and away not the most common source of blurry vision.
Q. Okay. And what would be more common?
A. A change in the refractive error, cataracts, corneal scars, a lot of other things.
Q. Tell me some more other things.
A. Retinal problems, central serous retinopathy, retinal detachments. You could have optic neuritis, which is

Page 205

had to be extra concerned and extra careful about an accurate reading of his intraocular pressure, correct?
MR. WHITE: Object to the form.
A. We did several tests that would have to do with him having angle closure glaucoma, and generally -- I don't know how much you've gotten to read in your book, but in angle closure glaucoma there is a tremendous asymmetry in the pressure between one eye and the other, as much as 30 or 40 points. The difference between 13 and 12 is one.
Q. Okay. But there were other tests available to you in the office that day, and you did not use them to measure his intraocular pressure, correct?
A. That's correct.
Q. Okay. And there were other ways of viewing his angle other than the slit lamp exam, and you didn't use those either, correct?
A. We did use a slit lamp exam.
Q. But you didn't use anything else?
A. To look in the anterior chamber angle?

Page 206

Q. Right.
A. No. We used the test that you use the slit lamp for, which was the von Herrick method.
Q. Okay. But the gonioscopy provides a superior view. Okay.
MR. ADAMS: You want to take a break? And I'd like that copy of the written history if we could. Thank you.
MR. WHITE: Sure.
(Brief recess.)
MR. ADAMS: I'm just going to right now -- I don't necessarily know that there's anything that I want to ask about here, but let's just attach it somehow. We'll just make that a part of this exhibit.
Q. (Mr. Adams continuing) And let me ask you, Dr. Bazemore. You agree that that is a form used by your office, correct?
A. Correct.

Page 207

Q. And it appears to be filled out by Kyle Bengtson at his visit -- apparently, his first visit?
A. Right.
Q. Okay. So that would go with the 2000 note, for the year 2000, like March 24th?
A. It would have been filled out then.
Q. All right. Thank you.
When Kyle Bengtson came in to see you on August the 20th, 2004, what eye problems do you believe he had at that time?
A. There were no problems found except for his refractive error. In the left eye, there was no change from the time before. In the right eye, there was a correction for astigmatism change, so it was recommended that he change the right lens in his glasses after a positive demonstration of the change was given to him.
Q. Okay. But other than changing his prescription and having him come back for recheck in one year, you didn't refer him for more tests or ask him to come back or

Page 208

anything like that, correct?
A. There were no other problems detected.
Q. So no referral to an ophthalmologist?
A. That's correct.
Q. And just so I understand, why did you not ask him to follow up with you sooner than one year?
A. There were no findings that would have indicated that he come back any sooner than that.
Q. Okay. And why no referral to an ophthalmologist?
A. There was no problems detected that would indicate that that be done.
Q. Okay. If a patient has had trauma to his eye in the past, can that cause angle closure glaucoma?
A. It could possibly cause a secondary type.
Q. And the standard of care in terms of your duty to be diligent in treatment and diagnosis is the same regardless of the origin of the angle closure, correct?
A. That's correct.